Enrollment Assessment
Family Residential & Sober Living
Children

▶ ***Enrollment Date:*** / / *mm dd yyyy*

▶ **ESM Client ID:**

Provider ID:

Questions (Q) marked with ▶ must be completed.

First Name: **Middle Initial:** **Last Name:** ***Suffix:***

▶ **1. Client Code:** ☐☐☐☐☐ ▶ **2. Intake/Clinician Initials:** ☐☐☐

▶ **3. Do you own or rent a house, apartment, or room?** ☐Yes ☐No *If the answer to Q. 3 is Yes, skip to Q. 5* **If parent owns, check that child owns.**

4. Are you Chronically Homeless? *(HUD Definition in Manual)* ☐Yes ☐No

▶ **5. ZIP Code of Last Permanent Address:** *Do **Not** put zip code of Program.* **If Newborn or child that has been in foster care since birth, use code 99999** *See manual for definition of Permanent.*

▶ **6. Where did you stay last night?**

1☐ Emergency shelter
2☐ Transitional housing for homeless persons
3☐ Permanent housing for formerly homeless
4☐ Psychiatric hospital or other psych. facility
5☐ Substance abuse treatment facility or detox
6☐ Hospital (non-psychiatric)
7☐ Jail, prison or juvenile detention facility
8☐ Room, apartment, or house that you own or rent
9☐ Staying or living with a family member
10☐ Staying or living with a friend
11☐ **Room, apartment, or house to which you cannot return (future return can be uncertain)**
12☐ Hotel or motel paid for without emergency shelter voucher
13☐ Foster care home or foster care group hm
14☐ Place not meant for habitation
15☐ Other
88☐ Refused

▶ **7a. Do you consider yourself to be transgender?** ☐Yes ☐No ☐Refused **If young child, check No or Refused.**

7b. If you answered Yes to Q. 7a, please specify: ☐Male to Female ☐Female to Male ☐Other, specify _____

▶ **8. Do you consider yourself to be:** ☐Heterosexual ☐Gay/Lesbian ☐Bisexual ☐Other, specify _____ ☐Refused **If young child, check Refused.**

▶ **9. Number of days between initial contact with program and the first available appointment :** 0

▶ **10. Source of Referral:** ☐DCF ☐Family ☐Residential Treatment Program

▶ **11. Frequency of attendance at self-help programs (e.g. AA, NA) in 30 days prior to Admission:** 99

▶ **12. Client Type** ☒Collateral

13. Additional Client Type (Check ALL that apply) *New* ☐Student ☐Pregnant ☐Postpartum ☐Probation ☐Federal Probation

▶ **14. Do you have children?** ☐Yes ☐No ☐Refused *If answer to Q. 14 is 'Yes', complete 14a-14d. If no, skip to Q. 15*

14a. Number Children Under 6: ☐ **14b. Number of Children 6-18:** 0 **14c. Children Over 18:** 0

14d. Are any of the children of the Native American **Indian race?** ☐Yes ☐No

▶ **15. Are you the primary caregiver for any children?** If yes, see manual. *If the client is the primary caregiver of children, you must assess as to the children's welfare and what arrangements have been made for their care in your full clinical assessment!!!* 1 ☐Yes 2 ☐No ☐Refused

▶ **16. Employment status at Enrollment** 9 ▶ **17. Number of days worked in the past 30 days?** 0

▶ **18. Where do you usually live?** (*Where has the client spent/slept most of the time over the last 12 months?*)

1 ☐ House or apartment
2 ☐ Room/boarding or sober house
3 ☐ Institution
4 ☐ Group home/treatment
5 ☐ Shelter/mission
6 ☐ On the streets
7 ☐ Foster Care
8 ☐ N/A Infant
88 ☐ Refused

▶ **19. Who do you live with?** ☒Parents **Collaterals End Here**